

APPLICATION FOR TEMPORARY TOTAL DISABILITY



1. EMPLOYEE'S DETAILS

Surname																						
First names																						
Date of birth	d	d	m	m	y	y	y	y	ID No.													
Employee no																						
Designation																						
Department																						
Residential address							Postal address															
Telephone numbers:																						
@ work (Code and No)								@ home (Code and No)														
Alternative contact No								Cell No														

Signature: _____

Date:

d	d	m	m	y	y	y	y
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Employee no:

--	--	--	--	--	--	--	--

2. DIRECT LINE MANAGER/SUPERVISOR

Initials & surname:			
Designation		Employee no.:	
Department		Contact number:	

Motivation from line:

Signature:

Date:

d	d	m	m	y	y	y	y
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3. HUMAN RESOURCES

Initials & surname:			
Contact address <small>Where correspondence has to be send for recommendations</small>			
Designation		Employee no.:	
Department		Contact number:	

Employee no:

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Employee's leave balance as on:

d	d	m	m	y	y	y	y
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Leave balance:

Occasional:

Sick:

Annual:

TTD leave previously approved:

TTD leave now applied for:

TTD leave period applied for: From

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

To

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

Signature:

Date:

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

3. MEDICAL ADVISOR – (PRO-ACTIVE HEALTH SOLUTIONS)

Initials & surname:

Designation

Contact number:

Signature:

Date of assessment:

d	d	m	m	y	y	y	y
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4. Medical Penal

Meeting Date:

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

RECOMMENDED

NOT RECOMMENDED

Employee no:

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Comments

Signature

5. APPROVAL BY GROUP EXECUTIVE: HUMAN RESOURCES OR AS PER DELEGATION OF AUTHORITY

Initials & surname:			
Designation		Employee no.:	

APPROVED

NOT APPROVED

Signature:

Date:

d	d	m	m	y	y	y	y
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Employee no:

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3. State the patient's prognosis.

4. What is the expected date of work resumption/ Period of the extended sick leave?

Doctor's Signature

Date

Date:

**SOUTH AFRICAN POST OFFICE
LIMITED**

To:

497 Schubart Street
Pretoria Central
0002

PO Box 10 000
Pretoria
0001



Tel: 012 401 7366
Cell: 082 419 7567
Fax: 086 500 8397

E-mail: maureen.mpata@postoffice.co.za

Dear Dr.....

Patient name	
Unique number	

The patient is applying for extended sick leave as he/she has exhausted all his/her sick leave. May you please assist him/her by providing him/her with a **comprehensive medical report** so that we can forward it to the insurer.

Attached is a form that you may fill or use to guide you as to which information is needed. **Incomplete filling of any field or insufficient information provided** may result in the delay of processing of the patient's application.

Please note that the patient is responsible for the payment of the services rendered.

Thanking you in anticipation

Yours truly

Dr MG Mpata
Senior Manager: Employee Wellness

